

Chronic Daily Headache Has Range of Causes

BY DAMIAN McNAMARA
Miami Bureau

SCOTTSDALE, ARIZ. — Consider a range of explanations when a chronic daily headache patient does not improve with standard therapy, Dr. Joel R. Saper suggested at a symposium sponsored by the American Headache Society.

Some top reasons include medication-overuse headache (formerly known as rebound headache), a wrong diagnosis, and psychobiologic or behavioral barriers to treatment, when a person with chronic daily headache fails to improve. Improperly selected or improperly dosed medication are other possible culprits, said Dr. Saper, founder and director of the Michigan Head Pain & Neurological Institute at the University of Michigan, Ann Arbor.

"My best two pieces of advice are to consider that individual as the first patient you've ever seen with chronic daily headache," he said, "and it's not daily chronic headache until you've ruled out everything else." The differential diagnosis includes the other primary headache disorders and organic causes of intractable headache such as sphenoid sinusitis, an Arnold-Chiari malformation, and pseudotumor cerebri.

"The more you treat patients with chronic daily headache, the more you learn you did not get it right the first time," Dr. Saper said.

Patients who take almost any headache medications 2 or 3 days a week for months are at higher risk for medication-overuse headache (Curr. Pain Headache Rep. 2005;9:430-5). This progressive disorder is characterized by predictable and escalating headache frequency and medication use in patients with pre-existing headache.

"If you start a drug and are not there to deal with its consequences, you put all of us at risk," Dr. Saper said. "You better be willing to monitor them" and change therapy when warranted.

Headache is a symptom of more than 300 illnesses, making diagnosis of a primary disorder difficult. Causes of headache include cerebral venous occlusion, Lyme disease, infiltrative disease, exposure to toxins, AIDS, and opportunistic meningitis.

Psychiatric, behavioral, and drug misuse barriers are more pervasive than perhaps is appreciated, Dr. Saper said. Remember the basics, such as a thorough physical examination, comprehensive history, and getting collateral information from relatives, he suggested.

"Are we dealing in some cases with challenging headaches or a challenging individual with headaches? It is important to ask when someone is not getting better," Dr. Saper said. Drug abuse and medication non-compliance are also possible when a patient is not improving, he added.

Interventional procedures are sometimes necessary to treat intractable headaches. A neural block-

ade such as an epidural or C2-C3 might help, or consider neural stimulation, Dr. Saper said.

Sometimes, hospitalization is required to reach a correct diagnosis. "An outpatient visit is a snapshot, a moment that you spend with that patient," he said. "When trained staff is with a patient 24 hours a day, you begin to learn something about that case you would not learn in an outpatient setting." For example, how does a patient interact with their family? Does the patient sneak down to the hospital cafeteria and eat something they are not supposed to? ■

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Acronym Helps Identify Red Flags in Acute Severe Headache

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

LAS VEGAS — TEASE-First in deciding when to order neuroimaging for headache presenting in the acute setting, Dr. John B. Chawluk said at a symposium sponsored by the American Headache Society.

The acronym will identify most red flags that accompany acute severe headache—signs that there may be a serious underlying problem that needs immediate attention, said Dr. Chawluk of Drexel University, Philadelphia.

Although contrast-enhanced magnetic resonance imaging is most sensitive for some of these underlying conditions—arterial dissection, meningoencephalitis, and abscess, for example—it may not be immediately available in the acute setting. In that case, it's best to go with computed tomography, which can usually be obtained very quickly.

Imaging is mandatory in any of these scenarios, Dr. Chawluk said:

► Trauma with headache. Use CT to identify skull fracture, acute hematoma, or subarachnoid hemorrhage.

► Escalating severity of headache under observation, including headache that does not respond to acute pharmacotherapy. Use CT to identify subarachnoid hemorrhage or hydrocephalus. If the results are negative, use subsequent contrast-enhanced MRI to identify meningitis, abscess, arteriovenous malformations, or neoplasm.

► Altered mental status with headache. Use contrast-enhanced CT to identify arteriovenous malformation, subarachnoid hemorrhage, meningitis, hydrocephalus, neoplasm, pituitary apoplexy, stroke, or subdural hematoma.

► Stiff neck. Use CT to identify subarachnoid hemorrhage.

► Examination abnormal, including fever or abnormal neurologic signs. Use CT to identify subarachnoid hemorrhage or hydrocephalus. Follow-up with contrast-enhanced MRI to identify stroke, tumor, meningoencephalitis, carotid/vertebral dissection, or venous thrombosis.

► First headache, or worst headache ever. Use CT to identify subarachnoid hemorrhage.

Headaches that occur suddenly upon exertion or strain are a concern, he said. A CT will pick up possible causes, including ruptured aneurysm, subarachnoid hemorrhage, or hydrocephalus. "If the CT is negative, move onto a contrast-enhanced MRI to look for abnormalities of the foramen magnum or other pathological processes more sensitively detected by MRI."

Underlying pathology is more commonly seen in the acute setting than in subacute or primary care settings, he said.

In the emergency department, probably about 10% of headache patients have some serious neurologic problems, and about 40% have headache related to systemic disease. The rest are primary headache disorders, Dr. Chawluk added. ■

Newly Recognized Syndrome Causes Dizziness and Headache

BY ELAINE ZABLOCKI
Contributing Writer

LOS ANGELES — Vertical heterophoria is a newly recognized syndrome responsible for a high proportion of otherwise undiagnosable cases of dizziness and headaches, Dr. Arthur J. Rosner said at the annual meeting of the American Academy of Otolaryngology-Head and Neck Surgery Foundation.

In vertical heterophoria, one eye sees an image higher than the other eye does. This may be caused by the relative position of the eyes or to neurologic or muscular anomalies. The brain is intolerant of the unclear image and responds with compensatory mechanisms. The resulting strain can lead to symptoms that mimic sinusitis, inner ear disorders, and migraine headaches.

"When patients present with dizziness, I check for possible causes such as benign paroxysmal positional vertigo, sinusitis, and tumors," Dr. Rosner said in an interview. "When I rule out the more common diagnoses and I'm left with unexplained dizziness, 90% of the time it turns out to be due to vertical heterophoria."

Dr. Rosner, an otolaryngologist in private practice in Sterling Heights, Mich., uses a Quality of Vision questionnaire to

evaluate patients, asking whether they experience double vision, blurred vision, poor depth perception, and other visual problems. Those who score high on the questionnaire are referred to an optometrist.

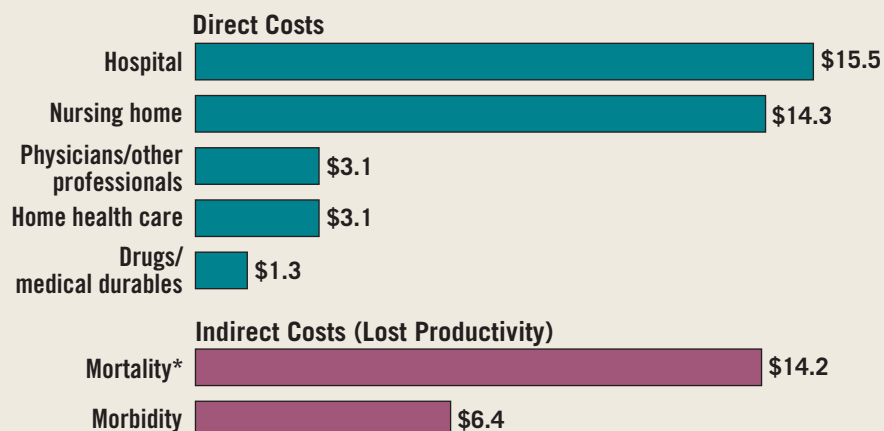
In his study, 100 patients were sent for optometry evaluation, and 29 of these had vertical heterophoria. They were treated with new glasses using fractional units of vertical and horizontal prism. After treatment, symptoms were evaluated using the Quality of Vision questionnaire, which showed a mean symptom reduction of 50%.

So far, Dr. Rosner has treated more than 500 patients with vertical heterophoria, most of them successfully. The symptoms that were most improved included dizziness on bending down and standing up, blinking to clear vision of distant objects, unsteadiness when walking, fatigue when reading, and poor depth perception.

To identify this often unrecognized condition, physicians should question patients more vigilantly about visual stimulation that leads to dizziness, Dr. Rosner said. "Someone may be seeing double, having problems reading, or bumping into things, but they don't volunteer this information because they think it's normal. They've lived with it for years." Additional research is needed to determine the causes of and treatments for the disorder, he added. ■

DATA WATCH

Estimated Costs of Stroke for 2006 (in billions)



*Estimated loss in future earnings of persons who will die in 2006, discounted at 3%.
Source: American Heart Association